90-328

No. _____

Supreme Court, U.S.
FILED
AUG 21 1990
JOSEPH F. SPANIOL, JR.
CLERK

In the Supreme Court of the United States

OCTOBER TERM, 1989

BODIMETRIC HEALTH SERVICES, INC.,
BODIMETRIC HOME CARE, INC., AND
AMERICAN SERVICE BUREAU, INC.,
PETITIONERS,

v.

AETNA LIFE & CASUALTY AND
AETNA LIFE INSURANCE COMPANY,
RESPONDENTS.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

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QUESTION PRESENTED

Whether 42 U.S.C. § 405(h) precludes a suit based on state tort and contract law for money damages, when the suit is by a Medicare provider and related corporations against a private party for wrongdoing that was contrary to its contract as a Medicare intermediary, and when the plaintiffs do not seek payment of Medicare benefits?

PARTIES TO THE PROCEEDINGS BELOW

The parties to the proceedings below were: the Petitioners Bodimetric Health Services, Inc., Bodimetric Home Care, Inc.,[1] and American Service Bureau, Inc., as appellants/cross-appellees; the Respondents Aetna Life & Casualty and Aetna Life Insurance Company, as appellees; and the United States of America as cross-appellant. The district court denied as moot the motion of the United States to intervene. The court of appeals did not consider the motion to intervene in light of its ruling on jurisdiction.

American Service Bureau, Inc. is the parent company of Bodimetric Health Services, Inc. and Bodimetric Home Care, Inc. Lifetime Corporation is the parent company of American Service Bureau, Inc.

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[1] Bodimetric Home Care, Inc., has changed its name to Bodimetric Profiles, Inc. For consistency with the decisions below, we will continue to refer to this entity as Bodimetric Home Care, Inc.

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RESPONDENTS.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

The Petitioners Bodimetric Health Services, Inc., Bodimetric Home Care, Inc., and American Service Bureau, Inc., respectfully pray that a Writ of Certiorari issue to review the judgment and opinion of the United States Court of Appeals for the Seventh Circuit, entered in the above-entitled proceeding on May 25, 1990.

OPINIONS BELOW

The opinion of the Court of Appeals for the Seventh Circuit, as amended by an order dated June 5, 1990, is reported at 903 F.2d 480 (1990), and is reprinted in the appendix hereto, p. 1a, *infra*. The opinion of the United States District Court for the Northern District of Illinois (Moran, J.) is reported at 706 F. Supp. 619 (1989), and is reprinted in the appendix hereto, p. 22a, *infra*.

JURISDICTION

The judgment of the Court of Appeals for the Seventh Circuit sought to be reviewed was issued and entered on May 25, 1990. The jurisdiction of this Court to review the judgment of the Seventh Circuit is invoked under 28 U.S.C. § 1254(1) (1990 Supp.).

STATUTES INVOLVED

42 U.S.C. § 405 (1990) Evidence, procedure, and certification for payments

(h) Finality of Secretary's decision

The findings and decisions of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Secretary, or any officer or employee thereof shall be brought under section 1331 or 1346 of title 28 to recover on any claim arising under this title.

42 U.S.C. § 1395ff (1983) Determinations of Secretary

(a) Entitlement to and amount of benefits

The determination of whether an individual is entitled to benefits under part A or part B of this subchapter, and the determination of the amount of benefits under part A of this subchapter, shall be made by the Secretary in accordance with regulations prescribed by him.

(b) Appeal by individuals

(1) Any individual dissatisfied with any determination under subsection (a) of this section as to—

(A) whether he meets the conditions of section 426 or section 426a of this title, or

(B) whether he is eligible to enroll and has enrolled pursuant to the provisions of part B of this subchapter or section 1395i-2 of this title, or

(C) the amount of benefits under part A of this subchapter (including a determination where such amount is determined to be zero)

shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 405(b) of this title and to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title.

(2) Notwithstanding the provisions of subparagraph (C) of paragraph (1) of this subsection, a hearing shall not be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than $100; nor shall judicial review be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than $1,000.

* * *

STATEMENT OF THE CASE

Petitioner Bodimetric Health Services, Inc. ("BHS") owned and operated a chain of fifteen home health agencies, each of which was certified to provide services to the elderly under the Medicare program. Certified home health agencies are entitled to Medicare reimbursement of the lesser of their reasonable costs or customary charges for services to Medicare beneficiaries. 42 U.S.C. § 1395f(b) (1983, 1990 Supp.). "Reasonable cost" in-

cludes the cost incurred by organizations related to the home health agency through ownership or control. 42 C.F.R. § 413.17 (1989).

A group of home health agencies may nominate a private organization, generally a private insurance company, to act as a fiscal intermediary for the purpose of processing claims and paying the home health agency for services rendered to Medicare beneficiaries. 42 U.S.C. §§ 1395h(a), (e)(4) (1983, 1990 Supp.). If the Health Care Financing Administration ("HCFA") [2] approves the nomination, HCFA, on behalf of the Secretary of Health and Human Services ("Secretary" and "HHS" respectively), will enter into a contract with the nominated organization to act as a fiscal intermediary for the home health agency. *Id.*; 42 C.F.R. Part 421 (1989). Under that contract, the intermediary is responsible for reviewing claims for compliance with coverage requirements, determining the reasonable costs of services, making payments directly to the home health agencies for covered services provided to Medicare beneficiaries, providing consultative services to home health agencies, communicating to home health agencies any information or instructions from HCFA, auditing home health agency records and assisting home health agencies with utilization review activities. *Id.* at § 421.100.

Although the final determination of the amount of reimbursement to be paid to a home health agency is made at year end, the fiscal intermediary reviews, processes and pays claims submitted by a home health agency throughout the year on a per visit basis. At the end of the fiscal year, the home health agency submits a cost report which

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[2] HCFA is the component of the United States Department of Health and Human Services that is responsible for the operation of the Medicare program.

is audited by the intermediary. The intermediary then reconciles individual claims payments made during the year with the amount of reimbursement due according to the cost report, determines any overpayments or underpayments, and issues a determination as to the final amount of Medicare reimbursement due the home health agency. 42 U.S.C. § 1395g (1983, 1990 Supp.).

When an individual claim submitted during the year by the home health agency is denied on the grounds that the services are not reasonable or medically necessary or constitute custodial care, the Medicare beneficiary may request reconsideration of the denial by the intermediary, 42 C.F.R. § 405.710(b) (1989). If on reconsideration the intermediary affirms the denial and the amount of the claim is at least $100, the beneficiary has a right to a hearing before an administrative law judge. 42 U.S.C. § 1395ff. The decision may also be reviewed by the Appeals Council of HHS. 42 C.F.R. § 405.724 (1989). Judicial review of the decision of the administrative law judge or Appeals Council may be obtained if the amount in controversy is at least $1,000. 42 U.S.C. § 1395ff.

During the period involved in this suit, denials of claims for home health benefits for any reason other than for a lack of medical necessity or for custodial care were not appealable at all.[3] Although home health agencies had been granted none of the appeal rights afforded to Medicare beneficiaries with respect to such intermediary determinations, Congress did amend section 1395ff to prohibit the Secretary from denying home health agencies the opportunity to represent beneficiaries at such hearings.

The BHS home health agencies began providing home health services to Medicare beneficiaries in 1980. From

[3] Congress subsequently amended § 1395ff to permit appeals of "technical denials," effective for denials occurring on or after July 1, 1987. Pub. L. 99-509, § 9313, 100 Stat. 2002-2003 (1986).

1980 until 1984, HCFA's Office of Direct Reimbursement ("ODR") acted as their fiscal intermediary. ODR reviewed, processed and paid all claims, and issued virtually no denials of individual claims.[4]

In 1984, HCFA determined that ODR could no longer act as fiscal intermediary for home health agencies. At that point, BHS nominated Aetna Life Insurance Company ("Aetna") to act as its fiscal intermediary through Aetna's Illinois office. From 1984 to the beginning of 1985, Aetna, under intermediary contract with HCFA, processed and paid all BHS's claims for home health services, and issued virtually no denials for claims submitted during the year. The BHS agencies continued to provide services and to document and submit claims in the same manner as they had since 1980.

The Petitioners believe that in or about January 1985 HCFA performed a contractor evaluation of Aetna which was critical of its performance as a fiscal intermediary, and particularly critical of the lack of denials resulting from Aetna's medical audits. Immediately following this review by HCFA, Aetna changed its policies and practices and adopted internal, unpublished rules for reviewing home health agency claims. Retroactive application of these policies, without any notice to BHS, resulted in the denial of a high percentage of BHS claims. The purpose of this wholesale change in Aetna's behavior, BHS alleges, was to raise its denial rate and, hence, improve its contract performance evaluation, so that it could retain its contract with HCFA as an intermediary.

Beginning in February and March of 1985, Aetna began to deny claims that were submitted for payment as early as 1983. In the six months from February 1985 to July 1985,

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[4] The Petitioners' allegations are generally set forth in the decision of the district court, 706 F.Supp. at 622-624, 27a-30a, *infra*.

Aetna denied approximately 20,000 Medicare home health visits performed by the BHS agencies. Denials continued after that time, with a total of over 26,000 BHS visits denied for services rendered in 1983, 1984, 1985 and 1986.

While Aetna was told by HCFA that for every dollar spent on medical review, five dollars should be disallowed, Aetna in fact achieved a 22.1-to-one ratio of dollars denied to dollars spent. In 1985, Aetna denied 50.8% of home health agency claims; for the first quarter of fiscal 1986, its denial rate was 86.9%.[5]

Aetna's action in denying massive quantities of claims was a self-serving quest to improve its performance evaluation, which was in violation of its express contractual obligation not to use its position as a Medicare contractor for purposes of furthering its private business interests or gain.

Many of the denials were for technical reasons (e.g., an assertion that the patient was not homebound) for which Aetna knew BHS had no appeal rights. When BHS requested a meeting with Aetna, Aetna assured them that nothing was amiss and Aetna was simply catching up on a backlog of claims. Thus, Aetna induced BHS to continue to deliver home health services, and to document and submit claims in the same manner as previously. At a later time, when the denials continued, Aetna refused to respond to inquiries for assistance from BHS.

BHS appealed those denials for which it had appeal rights to administrative law judges. Over 88% of the denials were reversed, including 99% of the denials where

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[5] Amended Complaint, ¶ 26. In comparison, the denial rate of home health agency claims by intermediaries nationally was 3.8% in the last quarter of 1985, and ranged from 3.7% to 7.5% during the four quarters of 1986. Health Care Financing Admin., *Report to Congress and the Health Care Financing Administration from the Advisory Committee on Medicare Home Health Care* 37 (1989).

a BHS representative appeared in person and argued for reversal.

As a result of the avalanche of denials, BHS's cash flow was severely damaged. In addition, BHS had to hire and train large numbers of employees to help the agencies respond to massive numbers of denials, and lost many key personnel who were discouraged by the denials. As a result of the devastating financial strain caused by Aetna's willful actions, BHS was forced in early 1986 to sell six of its home health agencies at a loss and to close its remaining agencies.

Petitioner Bodimetric Home Care, Inc. ("BHC") owned and operated a chain of non-Medicare private duty nursing agencies at most of the same locations as the BHS home health agencies. The BHC agencies shared employees and administrative services with the BHS agencies. As a result of the forced sale or closure of the BHS agencies, the BHC agencies could not support the total administrative costs of their locations. BHC was thus forced to sell at a loss or close all of its agencies.

Petitioner American Service Bureau, Inc. ("ASB") is the parent corporation of both BHS and BHC. It incurred substantial losses as a result of the forced sale or closure of the BHS and BHC agencies, including both the loss of funds invested to start up BHS and BHC, and an $800,000 working capital loan to BHS made as a result of the financial stress caused by Aetna's massive rate of denials.

Petitioners BHS, BHC and ASB brought suit against Aetna alone in federal district court under diversity and civil RICO jurisdiction to recover damages from Aetna for the harm caused by Aetna's wrongful and fraudulent conduct.[6] They asserted the following tort and contract ac-

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[6] In the court of appeals, Petitioners withdrew the civil RICO count as a basis for federal court jurisdiction.

tions under Illinois state law: fraud, fraudulent concealment, negligent misrepresentation, breach of contractual relationship, breach of third party beneficiary relationship, tortious breach of implied covenant of good faith and fair dealing, breach of fiduciary duty, liability for intended consequences, and intentional harm to property interests. In addition, they alleged violations of civil RICO.

The Petitioners did not name any federal defendants, and sought no payment of Medicare benefits from the United States or from the Medicare Trust Fund.[7] BHS has

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[7] A small portion of the damages sought by the Petitioners consists of the value of claims which were denied by Aetna and reversed on appeal, but which have not yet been paid by Aetna. Whether these amounts are appropriate damages against Aetna cannot be determined until after the completion of the discovery phase of this litigation. If Aetna has been authorized to pay these amounts but has refused to do so as part of its scheme to ensure renewal of its intermediary contract, then these are appropriate damages against Aetna. If, however, Aetna has simply not yet been informed that the denials have been reversed on appeal and therefore has not yet been authorized to pay these claims, these amounts could be collected only from the Secretary and may not be sought as damages against Aetna.

Another portion of the Petitioners' damages relates to claims which were wrongfully denied and for which there is no administrative appeal process. Aetna denied these as part of its overall scheme to enhance its denial rate for its own benefit, as a way of improving its "cost to savings" denial ratio, knowing full well that there was no way that BHS could challenge the denials. Therefore, the Petitioners claimed the value of these denials *not as benefits* under the Medicare program to be paid from the Medicare Trust Fund, but as one element of damages caused by Aetna's own wrongful scheme, and to be paid by Aetna.

To cause BHS' entire suit to be dismissed because two out of the dozen categories of damages relate to denied claims would be the proverbial "tail wagging the dog." In any event, if the Court determines these two categories cannot be pursued in this action, the Petitioners should be permitted to sever them, and to proceed with its lawsuit to recover the remaining damages from Aetna.

pursued whatever administrative remedies it had, and has no other remedies through which it can seek recovery for the harm it suffered.

Aetna moved to dismiss the amended complaint for lack of subject matter jurisdiction, alleging that the exclusive review mechanisms of the Medicare statute barred the Petitioners from pursuing their causes of action under state law. The United States moved to intervene in the district court action. The district court granted Aetna's motion to dismiss, finding that the Petitioners' action was intertwined with claims for Medicare benefits and, therefore, the administrative review mechanisms in the statute were exclusive. The district court also denied the United States' motion to intervene as moot.

The Petitioners appealed to the Seventh Circuit, which affirmed the decision of the district court. The court of appeals concluded that the Petitioners' claims for damages against Aetna under state tort and contract law "arise under" the Medicare statute for purposes of 42 U.S.C. § 405(h), and constitute a challenge to an "amount determination" which is appealable only under the administrative mechanisms provided in 42 U.S.C. § 1395ff. Thus, the court held that the only relief to which Petitioners are entitled are those limited appeal rights in the statute for beneficiaries to appeal benefit determinations, which BHS has pursued separately on behalf of the beneficiaries. The court of appeals also held that a fiscal intermediary is an "officer or employee" of the United States as that term is used in section 405(h) and further determined that section 405(h) prohibits actions brought under diversity jurisdiction against such persons. Because the appellate court ruled that the district court lacked subject matter jurisdiction to hear the case, the court did not address Aetna's defense of official immunity or the government's motion to intervene.

REASONS FOR GRANTING THE WRIT

The Seventh Circuit has adopted a wholly unprecedented and unwarranted extension of 42 U.S.C. § 405(h). The court held that section 405(h) precludes a state law action brought by a Medicare provider against a private company (the fiscal intermediary) for conduct wholly outside the company's federal role, seeking damages other than federal benefits directly from the private company. That ruling is insupportable under section 405(h), conflicts with decisions of this Court and other courts, and is important. This Court should grant review.

Section 405(h) does not cover this suit. Section 405(h) applies only to certain claims arising under federal law and brought against the federal government or its agents for conduct within the scope of their federal roles. Nothing in the provision reflects any congressional intent to take the extraordinary step of precluding recovery through traditional state law remedies for private wrongs committed for private gain. The Seventh Circuit's willingness to infer such an intent in the face of carefully limited statutory language was erroneous. *See Westfall v. Erwin*, 484 U.S. 292, 295 (1988) (Court is reluctant to infer federal immunity that denies compensation to injured party with otherwise meritorious state-law claims); *Silkwood v. Kerr-McGee Corp.*, 464 U.S. 238, 251 (1984) ("It is difficult to believe that Congress would, without comment, remove all means of judicial recourse for those injured by illegal conduct.").

The Seventh Circuit's ruling conflicts with several decisions, most notably the Eighth Circuit's decision in *Rochester Methodist Hospital v. Travelers Insurance Co.*, 728 F.2d 1006 (8th Cir. 1984). The Eighth Circuit, clearly cognizant of section 405(h), affirmed a district court's award of damages under state law in favor of a Medicare provider against a fiscal intermediary, explaining that the suit was not to be equated with a suit against the govern-

ment itself because the wrongs alleged were outside the scope of the intermediary's federal role. The Seventh Circuit, by invoking section 405(h) to foreclose access to the courts, has totally prevented such a suit from being pursued.

The Seventh Circuit's ruling is also inconsistent with this Court's interpretation of section 405(h). The court of appeals applied section 405(h) even to claims for damages other than federal benefits and even to claims on which relief could not be granted in federal administrative proceedings, contrary to *Bowen v. Michigan Academy of Family Physicians*, 476 U.S. 667 (1986). Such claims—even if made under federal law, but *a fortiori* if made under *state* law—are wholly outside the ambit of the decisions on which the Seventh Circuit principally relied, *Heckler v. Ringer*, 466 U.S. 602 (1984), and *United States v. Erika*, 456 U.S. 201 (1982). The present case implicates none of the policies of judicial efficiency and deference to administrative processes on which those decisions rest.

The issue presented by the Seventh Circuit's decision is important. By curtailing suits by Medicare providers against fiscal intermediaries, the decision below would leave serious injuries uncompensated and free intermediaries from the normal check on wrongful acts against Medicare providers. Review is warranted to prevent such a result, which has not been congressionally commanded. Review is also warranted to provide much-needed clarification of section 405(h), whose meaning has troubled the lower courts and, as this Court noted in *Schweiker v. Chilicky*, 487 U.S. 412, 419 n.3 (1988), remains unsettled.

I. THE DECISION BELOW IS IN DIRECT CONFICT WITH *ROCHESTER METHODIST HOSPITAL V. TRAVELERS INSURANCE CO.*, 728 F.2d 1006 (8TH CIR. 1984), WHICH PERMITTED A PROVIDER SUIT AGAINST AN INTERMEDIARY FOR DAMAGES UNDER STATE LAW.

The relevant statutory language from 42 U.S.C. § 405(h) on which the conflict between the Seventh and

Eighth Circuits is grounded is the third sentence, which reads:

> No action against the United States, the Secretary, or any officer or employee thereof shall be brought under Section 1331 or 1346 of Title 28 to recover on any claim arising under this title.[8]

In *Schweiker v. Chilicky*, 487 U.S. 412 (1988), this Court addressed that statutory language in the context of a claim for consequential damages against government officials arising from the denial of disability benefits, stating:

> We continue to believe that the exact scope of the third sentence's restriction on federal question jurisdiction is not free from doubt.

Id. at 419 n.3.

While there may be doubt regarding the scope of that preclusive language on federal-question jurisdiction over claims for damages flowing from the administration of federal benefits programs, there should be no doubt as to whether that language precludes all state law remedies in fraud, tort or contract for such damages. Simply put, the statutory language does not even address that issue. Rather, it applies to actions that seek, directly or indirectly, to recover on "claims arising under" the statute, i.e., claims for benefits payable from governmental funds.

Notwithstanding the absence of any language in section 405(h) addressing, let alone precluding, state law remedies for harm caused Medicare providers by the wrongdoing of intermediaries, the Seventh Circuit ruled:

> BHS' challenge to Aetna's method of processing its claims, therefore, is directly controlled by the provisions of Section 405(h). The district court thus prop-

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[8] This section is incorporated into the Medicare portion of the statute by 42 U.S.C. § 1395ii (1990 Supp.).

> erly found that it lacked subject matter jurisdiction to consider Bodimetric's [BHS'] claims.

903 F.2d at 489-90, 20a, *infra*. While this language affirms the district court's finding that it lacked diversity jurisdiction, the Seventh Circuit's opinion would also appear to hold that section 405(h) precludes jurisdiction in both state and federal court.[9] 903 F.2d at 486 n.5 and 490, 13a and 21a, *infra*. In reaching its finding, the Seventh Circuit acknowledged that the damages sought by the Petitioners would not be recoverable through the administrative process, *id*. at 486 n.5, 13a, *infra*, because they do not consist of lost Medicare reimbursement but rather are for economic damages flowing directly from the intermediary's wrongful conduct.

The Seventh Circuit's ruling below is in direct conflict with the decision of the Eighth Circuit in *Rochester Methodist Hospital v. Travelers Insurance Co.*, 728 F.2d 1006 (8th Cir. 1984). In *Rochester* the Eighth Circuit affirmed a case in which the District of Minnesota assumed diversity jurisdiction, and upheld the district court's finding that a fiscal intermediary was liable under state law to the provider for loss of Medicare reimbursement flowing from the provider's reliance on the intermediary's fraudulent misrepresentations.

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[9] That ruling would preclude remedies in the state courts in similar provider suits against intermediaries, such as *Lifechem, Inc. v. The Prudential Insurance Company of America*, Superior Court of New Jersey, Law Div., Middlesex Co., Docket No. W-018751-89, and *Monsour Medical Center v. Blue Cross of Western Pennsylvania*, No. GD 84-12937, Court of Common Pleas, Allegheny Co., Pennsylvania. It would also cause considerable confusion in cases before the bankruptcy court, such as *In re Town & Country Home Nursing Services, Inc.*, 112 B.R. 329 (9th Cir. BAP 1990), *appeal pending* No. 90-55621 (9th Cir.) (Medicare provider's assertion of state tort and contract actions against intermediary and Secretary in context of bankruptcy proceeding held to be within jurisdiction of bankruptcy court).

Although the *Rochester* opinion expressly addresses only timeliness of appeal and sovereign immunity as possible bars to judicial review, it is clear that the Eighth Circuit was aware of section 405(h) and its potential applicability. Addressing the district court's initial dismissal of the case, prior to severance of the provider's claims against the Department of Health and Human Services, the *Rochester* court stated:

> The District Court held that 42 U.S.C. § 405(h) (1976) barred any jurisdiction that it may have under 28 U.S.C. § 1331 (Supp. V 1981); that it lacked jurisdiction under 42 U.S.C. § 1395oo (1976 & Supp. V 1981); and that there was no diversity of citizenship sufficient to confer jurisdiction under 28 U.S.C. § 1332 (1976) because the United States is not a citizen of any state.

Id. at 1010 n.6. Once the claim against the United States was severed, the case against Travelers for damages for its wrongful action proceeded under diversity jurisdiction. The clear but unstated points arising from the Eighth Circuit's acknowledgment of section 405(h) and the provider's award of $142,320 in damages against the intermediary, is the *sub silentio* ruling that, although section 405(h) may bar federal question jurisdiction over the Secretary or HHS for claims for Medicare reimbursement outside of the context of the statutory process, it does not bar state law claims for damages arising from the intermediary's wrongful conduct in the discharge of its functions. Moreover, it should be noted that, in *Rochester*, unlike the case at bar, the measure of damages appears to be solely the amount of Medicare reimbursement lost.[10]

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[10] A second case in which a federal court has assumed jurisdiction over a provider's claims against an intermediary in its own private capacity is *Group Health Inc. v. Blue Cross Association*, 793 F.2d 491

The Eighth Circuit was correct in affirming the lower court's decision in *Rochester*, which was grounded in diversity jurisdiction. The Seventh Circuit erred by denying diversity jurisdiction in the instant case. Because of the manifest injustice flowing from the denial of the right to a judicial remedy with respect to the significant damages incurred by Petitioners at the hands of an intermediary acting in its own self-interest, this Court should grant the Writ and resolve the conflict between the Seventh and Eighth Circuits in favor of a right on the part of Petitioners to seek a judicial remedy.

II. THE DECISION BELOW CONFLICTS WITH *BOWEN V. MICHIGAN ACADEMY OF FAMILY PHYSICIANS*, 476 U.S. 667 (1986).

In *Bowen v. Michigan Academy of Family Physicians*, 476 U.S. 667 (1986), this court unanimously [11] found that sections 405(h) and 1395ff did not preclude judicial review under federal question jurisdiction of the methods by which Part B payments are computed, as opposed to the computation of a specific payment amount. The *Michigan Academy* Court reviewed the legislative history of the 1972 amendment of section 1395ff, which indicated that there was no provision for an administrative appeal to the Secretary or for judicial review "on matters *solely involving amounts of benefits under part B*." 476 U.S. at 677

(2nd Cir. 1986), in which the Second Circuit dismissed an interlocutory appeal from the district court's decision at 625 F. Supp. 69 (S.D.N.Y. 1985) which had ruled that the intermediary was not entitled to summary judgment based on sovereign immunity. In that case, HHS was permitted to intervene and there was no discussion in either of the reported decisions concerning jurisdiction or section 405(h). The district court recently dismissed the suit on grounds of statute of limitations and immunity. 59 U.S.L.W. 2019 (S.D.N.Y. June 19, 1990).

[11] Justice Rehnquist took no part in this decision.

(quoting H.R. Conf. Rep. No. 92-1605, p. 61 (1972), U.S. Code Cong. & Admin. News 1972, pp. 4989, 5394) (emphasis added by Court). It then reconciled its finding of jurisdiction in *Michigan Academy* with its seemingly contrary decisions in *Heckler v. Ringer*, 466 U.S. 602 (1984), and *United States v. Erika*, 456 U.S. 201 (1982), by stating:

> The single sentence in which we disposed of respondents' claim [in *Ringer*] rested entirely on *Erika* and its companion case of *Schweiker v. McClure*. . . . We did not, in that single sentence, extend the preclusion of judicial review beyond the Part B "amount determinations" with which both *Erika* and that part of the *Ringer* opinion were concerned.

Michigan Academy, 476 U.S. at 677 n.7.

Similarly, in reconciling *Weinberger v. Salfi*, 422 U.S. 749 (1975) and *Ringer* with its decision in *Michigan Academy*, this Court pointed out that

> Section 405(h) does not apply by its own terms to Part B of the Medicare program, but is instead incorporated *mutatis mutandis* by § 1395ii. The legislative history of both the statute establishing the Medicare program and the 1972 amendments thereto [revising § 1395ff] *provides specific evidence of Congress' intent to foreclose review only of "amount determinations"* [emphasis added]—i.e., those "quite minor matters," [citation omitted] remitted finally and exclusively to adjudication by private insurance carriers in a "fair hearing." By the same token, matters which Congress did *not* delegate to private carriers [emphasis in original], such as challenges to the validity of the Secretary's instructions and regulations, are cognizable in courts of law.

Michigan Academy, 476 U.S. at 680 (footnote omitted).[12] The import of these quotes is clear: Congress intended

[12] There has been confusion in the lower courts over whether, in given situations along the continuum between *Erika* and *Michigan*

only to preclude jurisdiction over minor amount determination disputes.

In refusing to extend the jurisdictional limitations of sections 405(h) and 1395ff to substantial statutory and constitutional challenges to the administration of Part B of the Medicare program, the *Michigan Academy* Court relied on the strong presumption of reviewability which had not been overcome by a showing of clear and convincing evidence of congressional intent to foreclose judicial review of the challenges involved. If the Court applied this presumption to find jurisdiction in a suit against the government that did not seek payment of benefits, then *a fortiori* the presumption should also be applied to find juris-

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Academy, federal jurisdiction exists, notwithstanding section 405(h), for claims that in some way involve the Medicare program but do not seek the payment of benefits. The First Circuit, in *McCuin v. Secretary of Health and Human Services*, 817 F.2d 161 (1st Cir. 1987), concluded that in *Michigan Academy*, "[t]he Court has instructed us . . . to construe the word 'amount' [in section 1395ff] narrowly," *id.* at 165, and held that federal question jurisdiction existed for a challenge to the Secretary's interpretation of the reopening regulations.

Similarly, the Third Circuit determined that, in *Michigan Academy*, "the Supreme Court severely restricted the decision in *Ringer* and held that Congress' intent was to foreclose review only of amount determinations remitted finally and exclusively to adjudication by private carriers in a fair hearing. Thus to the extent the plaintiff's claims involve matters not within the statutory jurisdiction of the hearing officer, review jurisdiction may be available under § 1331." *Medical Fund-Philadelphia Geriatric Center v. Heckler*, 804 F.2d 33, 38 (3d Cir. 1986). Significantly, these cases, as well as others seeking section 1331 jurisdiction, did not seek economic damages against private parties but sought relief against the government.

In sharp contrast, the Seventh Circuit in this case gave an expansive reading to both the "amount determination" language of section 1395ff and the "claim arising under" language of section 405(h), so as to preclude jurisdiction. The granting of the Writ in this case is necessary to provide guidance to the lower courts.

diction in a suit against a private party for damages under state law causes of action.

As with the presumption of reviewability of agency action that guided the *Michigan Academy* Court, there is a similar policy of access to the courts to remedy wrongs done with regard to claims for damages against private parties such as Aetna. *See Murray's Lessee v. Hoboken Land & Improvement Co.*, 59 U.S. (18 How.) 272, 283 (1856) ("we do not consider Congress can . . . withdraw from judicial cognizance any matter which from its nature, is the subject of a suit at common law"). This Court should not assume Congress intended to abolish state common law remedies against private parties without some explicit statement of congressional intent to that effect. Both the language and the legislative history of sections 405(h) and 1395ff are silent on the issue of state common law remedies and speak only to actions for benefits.

The Seventh Circuit's decision conflicts with this Court's decision in *Michigan Academy*. Plaintiffs below were seeking under state law economic damages totalling in the millions of dollars resulting from an intermediary's conduct. They were *not* asking for judicial review of "amount determinations" or "quite minor matters remitted finally and exclusively to adjudication by private insurance carriers in a fair hearing." In the absence of statutory language in section 405(h) addressing state law remedies against intermediaries for wrongful conduct under such circumstances, the ruling below denying judicial review based upon sections 405(h) and 1395ff is contrary to *Michigan Academy*.[13]

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[13] The court below suggested that BHS could have raised its claims for economic or consequential damages grounded in state contract and tort law in hearings before the ALJs on the individual claim denials, 903 F.2d at 486, 13a, *infra*, but then conceded that the Secretary and the ALJ can give no relief for those damages, *id.* at

The decision below is contrary to *Michigan Academy* in another respect as well. Notwithstanding the facts that the preclusory language of section 405(h) is silent as to the state law remedies sought by BHS and that both section 1395ff (which has no preclusory language but rather is an affirmative grant of remedies) and its legislative history are silent on the issue, the court below ruled that section 405(h) precludes the remedy sought. To achieve that result, the Seventh Circuit had to engage in an interpretative process that resolved the statutory silence and the neutral language of those sections *against* review in every respect. That interpretative process can only be based upon what would amount to a presumption *against* reviewability and, as such, conflicts with the presumption in favor of reviewability reaffirmed in *Michigan Academy*.[14]

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486 n.5, 13a, *infra*. A right to be heard without a remedy is not a right. The *Michigan Academy* plaintiff could likewise have voiced its challenge to the regulation at a carrier hearing, but the carrier could grant no relief because it was bound by the regulations. For that very reason, this Court found federal question jurisdiction existed for a challenge to the regulation.

The suggestion of the court below that Petitioners' claims for consequential economic damages were committed to administrative review stretches credulity when Petitioners had no right of their own to be heard in the administrative forum—the only right to be heard under section 1395ff is that of the beneficiary. The provider may appear only as representative of the beneficiary and not in its own right. Thus, because only the Petitioners and not the beneficiaries suffered damages, there would be little reason for an ALJ to even admit such evidence regarding the Petitioners' economic harm.

[14] Absent interpretative guidance from this Court, the confusion in the lower courts over the proper interpretative approach to sections 405(h) and 1395ff will continue, with the courts vacillating between "broad" and "narrow" readings of the various words and phrases of those sections, producing inconsistent results.

III. THIS CASE INVOLVES IMPORTANT QUESTIONS OF FEDERAL LAW WHICH SHOULD BE SETTLED BY THIS COURT.

A. *By Precluding Both State And Federal Jurisdiction, The Seventh Circuit Would Grant Absolute Immunity Under Section 405(h) To Private Entities Contracting To Serve As Medicare Intermediaries.*

In its opinion below, the Seventh Circuit read the administrative and judicial remedies provided Medicare beneficiaries to challenge the merits of intermediary claims denials under section 1395ff as providing the exclusive remedy for claims by Petitioners against Aetna resulting from Aetna's actions under color of its intermediary contract. The court below then concluded that although section 1395ff does not afford the consequential economic damages sought by Petitioners under state tort and contract law, section 405(h) nevertheless precludes pursuit of such state law claims against private parties serving as fiscal intermediaries.

If Petitioners are correct in their reading of the opinion below, the Seventh Circuit read the interplay of sections 405(h) and 1395ff as precluding not only federal diversity jurisdiction over state law claims against intermediaries associated with their actions as intermediary but also jurisdiction in the state courts over such claims.[15] Given that the Secretary is the real party in interest for beneficiary challenges to intermediary denials under section 1395ff, the effect of precluding providers such as BHS from bringing suits for consequential economic damages under state law against intermediaries is quite simply to fashion an absolute immunity for such private contractors purporting to act under their intermediary

[15] This reading can only result in confusion in the state courts entertaining suits against intermediaries for consequential economic damages, as in the state court suits cited in n. 9, *supra*.

contracts—notwithstanding the fact that the conduct involved may violate the intermediary's contract and cause economic damages far beyond the mere loss of Medicare reimbursement. With sections 405(h) and 1395ff silent on the issue of jurisdiction over such state law claims, there is no basis to so immunize private parties from liability for the harm they do.

B. *The Seventh Circuit's Finding Of No Federal Diversity Jurisdiction Over Petitioner's State Law Claims Relies On Policies Which Are Inapplicable.*

The court below was misguided in its reliance on the policies and concerns on which the jurisdictional limitations of sections 405(h) and 1395ff are based. This Court should provide the guidance that will avoid such confusion over the scope of the jurisdictional bar arising from sections 405(h) and 1395ff.

The policies underlying the jurisdictional bar of section 405(h) and the limited appeal rights granted in section 1395ff that favor limiting access to the federal courts are based on concerns about judicial economy and utilization of the administrative process. Neither of these concerns apply to Petitioners' case (or similar cases) and therefore do not support the Seventh Circuit's denial of jurisdiction.

In *United States v. Erika, Inc.*, 456 U.S. 201 (1982), this Court ruled that Congress' failure to provide for administrative and judicial review in section 1395ff, coupled with legislative history demonstrating that Congress specifically intended "to avoid overloading the courts with quite minor matters," *id.* at 209, *quoting* 118 Cong. Rec. 33992 (1972) (Sen. Bennett), operated to deny Court of Claims jurisdiction to review challenges to the amounts of payment under Part B of the Medicare program.[16] That congressional

[16] Congress subsequently amended section 1395ff to include administrative and judicial review over the amount of Part B claims. Pub. L. No. 99-509, § 9341(a)(1)(A), 100 Stat. 2037 (1986).

concern underlying section 1395ff does not require the result reached by the Seventh Circuit for the following reasons.

First, to allow diversity jurisdiction for claims based on state law flowing from the conduct of an intermediary in violation of its contract will not result in an opening of the floodgates of "quite minor matters" that were the concern of the *Erika* Court and were described in *Michigan Academy*. That spectre is rendered nonexistent by the required jurisdictional amount of $50,000, with costs assessable against the plaintiff if the award is less. 28 U.S.C. § 1332 (1964, 1990 Supp.).

Second, the matters concerned in such litigation are seldom quite minor in nature—in the instant case, two out of the three Petitioners (BHS and BHC) were forced out of business. In short, plaintiffs must be assumed to have some basic level of financial responsibility in determining the cost/benefit ratio associated with the kind of expensive litigation involved in suits against intermediaries, with whom they must continue to work after the litigation, in their private capacity. Concern about a flood of litigation over quite minor matters in such a context is groundless.

Concerns about avoiding the administrative process are also without merit. In *Heckler v. Ringer*, 466 U.S. 602 (1984), involving a direct judicial challenge to the Secretary's denial of Medicare coverage for bilateral carotid body resection surgery, this Court declined federal question jurisdiction. It held that the challenging beneficiaries had not given the Secretary an opportunity to rule on a concrete claim for reimbursement, and thus had not satisfied the nonwaivable exhaustion requirement of section 405(g). Accordingly, their claims were barred by section 405(h). The Court noted that "the purpose of the exhaustion requirement is to prevent 'premature interference with agency processes' and to give the agency a chance 'to compile a record which is adequate for judicial review.' " Id. at

619, n. 12. The Court also noted that although the plaintiffs in *Ringer* sought declaratory relief, their claims were nonetheless inextricably intertwined with claims for benefits and thus barred by section 405(h) as a claim "arising under" the Medicare Act because a favorable declaratory judgment would lead to the payment of benefits. *Id.* at 615.

Allowing jurisdiction over BHS' claims for damages under state law does not eliminate the salutory effect of the exhaustion requirement of section 405(h). BHS has exhausted all available administrative remedies and has been successful in its pursuit of those remedies. Resort to administrative remedies, however, has not made and could not make Petitioners whole.

CONCLUSION

Because of the conflict between the Seventh and Eighth Circuits on whether section 405(h) bars jurisdiction over state law action arising from the wrongdoing of individuals or government contractors administering federal benefits programs, the failure of the Seventh Circuit to follow *Michigan Academy*, and the important policies to be reconciled, it is respectfully submitted that this Petition for Writ of Certiorari should be granted.

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In the
United States Court of Appeals
For the Seventh Circuit

Nos. 89-1428, 89-1570

BODIMETRIC HEALTH SERVICES, INCORPORATED,
BODIMETRIC HOME HEALTH CARE, INCORPORATED
and AMERICAN SERVICE BUREAU, INCORPORATED,
Plaintiffs-Appellants and Cross-Appellees,

v.

AETNA LIFE & CASUALTY,
Defendant-Appellee,

UNITED STATES OF AMERICA,
Intervenor-Cross-Appellant.

Appeal from the United States District Court
for the Northern District of Illinois, Eastern Division.
No. 87 C 3465—**James B. Moran,** *Judge.*

ARGUED DEC. 15, 1989—DECIDED MAY 25, 1990
AS AMENDED—JUNE 5, 1990

Before CUDAHY, EASTERBROOK and KANNE, Circuit Judges.

CUDAHY, Circuit Judge.

Bodimetric Health Services ("Bodimetric")[1] brought suit against Aetna Life & Casualty ("Aetna") for improp-

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[1] Unless otherwise indicated, we will refer to the appellants collectively as "Bodimetric."

erly denying reimbursement claims made under the Medicare Act, 42 U.S.C.A. section 1395 *et seq.* (West Supp. 1990). Aetna defended itself with a motion to dismiss for lack of subject matter jurisdiction, alleging that the exclusive review mechanisms of the Medicare Act barred Bodimetric from pursuing its challenge in federal court. The district court granted Aetna's motion. The question on appeal is whether the allegedly improper application of "exclusive" review mechanisms to Bodimetric's claim is actionable in the district court. We affirm.

I.

The facts of this case—as well as the underlying statutory provisions—are ably recited in the district court opinion. *Bodimetric Health Servs. v. Aetna Life & Casualty*, 706 F. Supp. 619 (N.D.Ill. 1989). We pause here only to note some of the more pertinent details involved in this appeal.

Bodimetric owned and operated fifteen home health agencies ("HHAs") that provided in-home medical services as an alternative to institutional treatment. All fifteen of these HHAs were certified as Medicare providers. Under Part A of the Medicare Act,[2] these HHAs generally are reimbursed for the lesser of their reasonable costs (in providing treatment) or customary charges for rendering services. 42 U.S.C. § 1395f(b) (1982). To obtain reimburse-

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[2] Part A of the Medicare Act provides insurance for hospitalization and post-hospitalization costs. Part B provides supplemental insurance that covers other medical and health services. *See New York State Dept. of Social Servs. v. Bowen*, 661 F.Supp. 1537, 1539 (S.D.N.Y. 1987), *rev'd on other grounds*, 846 F.2d 129 (2d Cir. 1988).

ment from so-called "fiscal intermediaries,"[3] section 1395f(a)(2)(C) requires a physician to certify that services are necessary, that the individual is confined to the home and that a plan of treatment has been developed. 42 U.S.C.A. § 1395f(a)(2)(C) (West Supp. 1990). Before 1984, the Health Care Financing Administration's Office of Direct Reimbursement ("ODR") acted as fiscal intermediary to Bodimetric by processing Bodimetric's claims under these provisions of the Act; apparently, ODR rarely denied any of Bodimetric's claims.

In 1984, the Health Care Financing Administration determined that ODR could no longer serve as Bodimetric's fiscal intermediary. In this situation, the provisions of the Medicare Act permit an HHA to nominate a public or private agency to act as fiscal intermediary. 42 U.S.C.A. § 1395h (West Supp. 1990). Bodimetric relied upon these provisions to nominate Aetna as its fiscal intermediary. Aetna, at first, provided reimbursement for virtually all of Bodimetric's claims. In early 1985, however, Bodimetric alleges that the Department of Health and Human Services released a contractor evaluation critical of Aetna's per-

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[3] "A fiscal intermediary is an entity that has contracted with the Secretary to determine for the Secretary whether services provided . . . are covered under the Medicare Act and the amount due the provider of services." *Homewood Professional Care Center, Ltd. v. Heckler*, 764 F.2d 1242, 1244 n.2 (7th Cir. 1985). The fiscal intermediary must determine whether HHA-submitted expenses are reasonable and necessary: in particular, it must

> review claims for compliance with coverage requirements, determine the reasonable cost of services, make payments directly to health care providers, provide consultative services, communicate to providers any information or instruction from HCFA [Health Care Financing Administration], audit provider records and assist with utilization review activities.

Bodimetric, 706 F.Supp. at 621; *see* 42 U.S.C.A. § 1395(h) (West Supp. 1990); 42 C.F.R. § 421.100 (1988).

formance as a fiscal intermediary. Because of this evaluation, Bodimetric charges, Aetna adopted a more restrictive approach that led to the denial of a substantial number of HHA claims. Plaintiffs' Complaint ¶¶ 23-24. "The purpose of Aetna's [new approach] was to raise its denial rate, and hence improve its contract performance evaluation, so that it could retain its contract with HCFA as a fiscal intermediary." Appellants' Brief at 8-9.

Officials of Aetna agreed to meet with officials of Bodimetric to discuss the denial of the claims. Bodimetric alleges that Aetna used these meetings to lull Bodimetric into believing that the denials were atypical while it continued to deny thousands of claims without regard to their underlying substance. In support of this charge, Bodimetric asserts that administrative law judges have reversed almost all of Aetna's denials where Bodimetric has entered an appearance and argued for reversal. *Bodimetric*, 706 F.Supp. at 623.

Aetna's arbitrary campaign of denials according to Bodimetric, led to the closing of Bodimetric's HHAs and, as a result caused Bodimetric to lose more than 8 million dollars. Consequently, Bodimetric filed suit in district court seeking damages due to Aetna's alleged fraud, fraudulent concealment, negligent misrepresentation, breach of contractual relationship, breach of third-party beneficiary relationship, tortious breach of implied covenant of good faith and fair dealing, breach of fiduciary duty, liability for intended consequences, intentional harm to property interest and violations of civil RICO. Aetna successfully moved for dismissal, noting that the district court did not have subject matter jurisdiction to consider the case.

II.

A. The Underlying Regulatory and Statutory System of Review

Congress provided elaborate review provisions to be used by parties dissatisfied with the initial disposition of their Medicare claims. *See* 42 U.S.C.A. §§ 405(h), 1395ff (1982 & West Supp. 1990). If a fiscal intermediary determines that certain HHA provided services are not "reasonable and necessary for the diagnosis or treatment of illness or injury," or otherwise are not covered by Medicare, the affected HHA may request reconsideration by the fiscal intermediary. 42 C.F.R. §§ 405.710(b), 405.711 (1988). Should this avenue prove unsuccessful, the provider (assuming the claim exceeds $100) may argue its case to an administrative law judge, 42 C.F.R. § 405.720 (1988), and may request an additional review by the Appeals Council. 42 C.F.R. § 405.724 (1988). Should the disputed amount exceed $1000, the HHA may seek judicial review of the final decision in federal district court. 42 C.F.R. § 405.730 (1988). Congress, as noted by Judge Moran, "intended the remedies provided by these review procedures to be exclusive." 706 F.Supp. at 621; *see* S.Rep. No. 404, 89th Cong., 1st Sess., *reprinted in* 1965 U.S. Code Cong. & Admin. News 1943, 1995.

The exclusive nature of these remedies is reflected in the statutory structure of the Medicare Act: after exhausting the provisions outlined in the regulations promulgated under 42 U.S.C. section 1395ff, many claimants, under the Medicare statutes, simply do not have recourse to the federal courts:

> The findings and decision of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or

> decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Secretary, or any officer or employee thereof shall be brought under section 1331 or 1346 of Title 28 to recover on any claim arising under this subchapter.

42 U.S.C. § 405(h) (1982). Put simply, "42 U.S.C. section 405(h) (as applied to Medicare by 42 U.S.C.A. section 1395ii) provides that any 'claim arising under' the Medicare program must be brought *exclusively* under section 405(g)," *Wilkins v. Sullivan*, 889 F.2d 135, 138 (7th Cir. 1989); individuals generally cannot otherwise obtain judicial review of certain actions that "arise under" this subchapter of the Medicare Act. Whether Bodimetric's state law charges (which we are asked to consider pursuant to our diversity jurisdiction) "arise under" the Medicare Act is one of the principal questions presented by this case.

B. Does Bodimetric's Claim "Arise Under" the Medicare Act?

At the outset, we observe that the Supreme Court has instructed us to read the term "arising under" broadly. *See Attorney Registration & Disciplinary Comm'n v. Schweiker*, 715 F.2d 282, 287 (7th Cir. 1983) ("[W]e cannot disregard the Supreme Court's admonition to read section 205(h) as written – that is, broadly."). The Court considered the scope of this section in *Heckler v. Ringer*, 466 U.S. 602, 104 S.Ct. 2013, 80 L.Ed.2d 622 (1984), and concluded that claims arising under other statutes may be barred by section 405(h) if they are also "inextricably intertwined" with benefits determinations under the Medicare Act. *Id.* at 622-24, 104 S.Ct. at 2025-26; *see Weinberger v. Salfi*, 422 U.S. 749, 760-61, 95 S.Ct. 2457, 2464, 45 L.Ed.2d 522 (1975) (presenting "standing and substantive basis" test). In *Ringer*, Medicare claimants mounted a stat-

utory and constitutional challenge to the Secretary of Health and Human Service's final decision prohibiting reimbursement for bilateral carotid body resection ("BCBR") claims. Although the claimants styled their challenge as a claim based upon the Medicare Act, the Administrative Procedure Act and the Due Process Clause, the Court noted that the plaintiffs' complaint was, "at bottom, a claim that they should be paid for their BCBR surgery." 466 U.S. at 614, 104 S.Ct. at 204. As such, the Court concluded that the claim was inextricably intertwined with the claim for benefits and was therefore barred by section 405(h).

Nonetheless, the Supreme Court has recognized that a party does not necessarily assert a claim under the Medicare Act merely by including the word "Medicare" in his challenge. Indeed the Court suggested in *Ringer* that certain Medicare-related claims may be "wholly collateral" to claims for benefits and therefore would not be barred from federal courts pursuant to section 405(h). 466 U.S. at 617-18, 104 S.Ct. at 2022-23. For example, Judge Bua concluded in *Beckless v. Heckler*, 622 F.Supp. 715 (N.D.Ill. 1985), that a class-action challenge to HHS regulations was not "inextricably intertwined" with a claim for benefits. *Id.* at 718.

In the case before us, Bodimetic declares that its state law claims against Aetna are not inextricably intertwined with a challenge under the Medicare Act to Aetna's denials of individual claims. Essentially, Bodimetric argues that it seeks damages from Aetna's own pocket, not from the Medicare Trust Fund. Moreover, Bodimetric maintains that it cannot raise its challenges to Aetna's unlawful behavior in the administrative hearings provided by the Medicare regulations, and that it does not have other regulatory avenues of relief in which it may pursue its claim. In the end, as we shall see, whether Bodimetric's claim for

damages is inextricably intertwined with a claim for Medicare benefits or wholly collateral to such a claim (or somewhere in between) depends largely upon whether this appeal more closely resembles *United States v. Erika, Inc.*, 456 U.S. 201, 102 S.Ct. 1650, 72 L.Ed.2d 12 (1982), or *Bowen v. Michigan Academy of Family Physicians*, 476 U.S. 667, 106 S.Ct. 2133, 90 L.Ed.2d 623 (1986).

C. Reconciling *Erika* and *Michigan Academy*: Judicial Review and the Supreme Court's Construction of Section 1395ff

Within the last decade, the Supreme Court has decided two cases, both by unanimous opinion,[4] that define the contours of judicial review under section 1395ff. In the first case, *United States v. Erika*, 456 U.S. 201, 102 S.Ct. 1650, 72 L.Ed.2d 12 (1982), the Court held that section 1395ff barred judicial review of a hearing officer's "amount of benefits" determination under Part B of the Medicare Act. The Court based its holding on Congress's calculated refusal to provide for judicial review of Part B awards in the face of an otherwise comprehensive statute:

> Section 1395ff thus distinguishes between two types of administrative decisions: eligibility determinations (that decide whether an individual is 65 or over or "disabled" within the meaning of the Medicare program) and amount determinations (that decide the amount of the Medicare payment to be made on a particular claim). Conspicuously, the statute fails to authorize further review for determinations of the amount of Part B awards. In the context of the statute's precisely drawn provisions, this omission provides persuasive evidence that Congress deliberately intended to foreclose further review of such claims.

456 U.S. at 208, 102 S.Ct. at 1654.

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[4] Chief Justice Rehnquist did not participate in *Michigan Academy*.

[1] The Court narrowed its *Erika* holding in *Bowen v. Michigan Academy of Family Physicians,* 476 U.S. 667, 106 S.Ct. 2133, 90 L.Ed.2d 623 (1986). There, the Court concluded that section 1395ff does *not* bar judicial review of claimant challenges *to the validity of administrative regulations* promulgated under the Medicare Act. The Court in *Michigan Academy* upheld *Erika*, but carefully limited its preclusion of judicial review to Part B amount determinations. The comprehensive Medicare statutory scheme, the Court observed,

> simply does not speak to challenges mounted against the *method* by which such amounts are to be determined rather than the *determinations* themselves. As the Secretary has made clear, "the legality, constitutional or otherwise, of any provision of the Act or regulations relevant to the Medicare Program" is not considered in a "fair hearing" held by a carrier to resolved a grievance related to a determination of the amount of a Part B award. As a result, an attack on the validity of a regulation is not the kind of administrative action that we described in *Erika* as an "amount determination" which decides "the amount of the Medicare payment to be made on a particular claim" and with respect to which the Act impliedly denies judicial review.

476 U.S. at 675-76, 106 S.Ct. at 2138 (emphasis in original) (footnote omitted). Thus, the Court in *Erika* and *Michigan Academy* recognized the differences between two types of Medicare claims: challenges to the amount of benefits to be paid are not reviewable, while challenges to the regulatory scheme under which the amount of benefits is calculated are reviewable. *Id.* at 675-78, 106 S.Ct. at 2138-39. *See, e.g., Texas Medical Ass'n v. Sullivan*, 875

F.2d 1160, 1164-66 (5th Cir.), *cert. denied*, ____ U.S. ____, 110 S.Ct. 573, 107 L.Ed.2d 568 (1989); *Association of Seat Lift Mfrs. v. Bowen*, 858 F.2d 308, 316 (6th Cir.1988), *cert. denied*, ____ U.S. ____, 109 S.Ct. 1528, 103 L.Ed.2d 833 (1989); *Medical Fund-Philadelphia Geriatric Center v. Heckler*, 804 F.2d 33, 38-39 (3d Cir.1986); *American Ambulance Serv. v. Sullivan*, 716 F.Supp. 861, 867-69 (E.D.Pa.1989); *United States v. Ruegsegger*, 702 F.Supp. 438, 446-47 (S.D.N.Y.1988) (all discussing relationship between *Erika* and *Michigan Academy*).

Other courts to have considered similar challenges have reached the same conclusion. In *Kuritzky v. Blue Shield*, 850 F.2d 126 (2d Cir.1988), *cert. denied*, ____ U.S. ____, 109 S.Ct. 787, 102 L.Ed.2d 778 (1989), the Second Circuit considered an appeal from a carrier's denial of physicians' reimbursement claims. Like Bodimetric, the *Kuritzky* physicians "complained . . . about the way in which their benefits were computed." *Id.* at 127. The court there held that the physicians' challenge was barred by the Medicare Act; it explained: "The distinction that emerges from *Erika* and *Michigan Academy* is that federal jurisdiction exists where there is a challenge to the validity of an agency rule or regulation but jurisdiction is lacking where the claim is merely that the insurance carrier misapplied or misinterpreted valid rules and regulations." *Kuritzky*, 850 F.2d at 128 (citations omitted). Since the physicians charged, at bottom, that the carrier had misapplied the regulations, the court concluded that *Erika*—and its jurisdictional bar—controlled. Similarly, in *Association of Seat Lift Manufacturers v. Bowen*, 858 F.2d 308 (6th Cir.1988), the Sixth Circuit refused to consider the reasonableness of a carrier's determination of the allowable charge for a seat lift chair; like the Second Circuit in *Kuritzky*, the court held that *Michigan Academy*

does not authorize judicial review of a carrier's *application* of administrative regulations. *Id.* at 316. And in *Neiman v. Secretary of the Department of HHS,* 722 F.Supp. 950 (E.D.N.Y.1988), a district court reasoned that *Erika* precluded federal review of Travelers Insurance Company's alleged failure to process a nursing home operator's Medicare applications as required by law.

The Second Circuit aptly summarized the distinction between *Michigan Academy* and *Erika* discussed in these recent cases:

> [T]he statement in *Michigan Academy* that challenges to the "method" of calculating benefits are reviewable as opposed to challenges to the "determinations themselves," which are not, clearly refers to the distinction between the rules, regulations, and statutes setting forth the proper computation method and the carrier's application of those provisions in determining the benefits owed. "Method" does not mean the carrier's method of applying the regulations, which *Erika* held was unreviewable; rather, it means the method set forth in the Secretary's regulatory scheme that prescribes how the carriers are to calculate benefits. *Michigan Academy* held that a challenge to this prescribed method was reviewable. Plaintiffs' claims allege only misapplication of valid regulations and are therefore unreviewable under *Erika.*

Kuritzky, 850 F.2d at 128 (citations omitted). Whether its complaint is with Aetna's rejection of one claim or a thousand claims, Bodimetric's grievance is, at bottom, a challenge to Aetna's approach to processing claims. Judicial review of such a challenge seems to be foreclosed by *Erika.*

Nonetheless, Bodimetric argues that the Court's holding in *Michigan Academy* should not be construed to permit judicial review of challenges to rules or regulations only; rather, Bodimetric asserts *Michigan Academy's* touchstone for judicial review is whether the challenge can be considered in an administrative hearing process. Dicta in *Michigan Academy* provides some support for this position: "We conclude . . . that those matters which Congress did *not* leave to be determined in a 'fair hearing' conducted by the carrier—including challenges to the validity of the Secretary's instructions and regulations—are not impliedly insulated from judicial review by 42 U.S.C. § 1395ff (1982 ed. and Supp. II)." 476 U.S. at 678, 106 S.Ct. at 2140 (emphasis in original). Bodimetric would have us believe that since it cannot challenge Aetna's benefits determinations in the administrative proceedings, the subject of these determinations should be judicially reviewable under the terms of *Michigan Academy*.

However, unlike the claimants in *Michigan Academy*, Bodimetric *can* challenge Aetna's benefits determinations (albeit on an individual basis) in the administrative proceedings. Indeed, Bodimetric acknowledges in its reply brief that it knows of no provision in the regulations prohibiting it from introducing the facts underlying its claims during the administrative hearings. Appellants' Reply Brief at 14. As Judge Moran remarked,

> the underlying allegations concerning Aetna's actions provide a basis for plaintiffs' administrative challenges under § 1395ff. True, the Secretary cannot adjudicate plaintiffs' claims under RICO and the common law; yet RICO and the common law would simply provide plaintiffs with theories to recover the value of lost benefits and consequential damages in a case where the underlying facts could be raised in the administrative process.

706 F.Supp. at 626. The ALJ's ability to consider the claims at issue here (and Bodimetric's right to advance them) lies in stark contrast to the Hearing Officer's express prohibition in *Michigan Academy* from reviewing legal challenges to the regulations promulgated under the strictures of the Medicare Act. 476 U.S. at 676 n. 6, 106 S.Ct. at 2138 n. 6.

Drawing from *Michigan Academy*, Bodimetric complains that its right to introduce its claims of Aetna's unlawful conduct in the administrative hearing process is rendered meaningless by the ALJ's inability to award money damages directly to Bodimetric based upon its state law tort and contract claims. While this complaint is not entirely groundless, it is somewhat misleading. Bodimetric *can* seek review of Aetna's denials through Medicare's administrative process; to be sure, the ALJ reviewing a denied claim may consider substantively different issues than might a state or federal judge reviewing a tort or contract claim, but the ALJ can provide relief to Bodimetric through the reversal of denied claims.[5] On the other hand, the claimants in *Michigan Academy* could not have sought review of the regulatory structure of the Medicare Act; even if the claimants had presented their arguments, Medicare's Hearing Officers still would have been completely powerless to make any changes in the existing regulations.

[2-4] Thus, Bodimetric's reading of *Michigan Academy* is too broad. A party cannot avoid the Medicare

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[5] Of course, we recognize that the administrative process outlined by section 1395ff may not afford Bodimetric all the relief it seeks pursuant to its state law claims. But Congress, through its establishment of a limited review process, has provided the remedies it deems necessary to effectuate the Medicare claims process. *Neiman*, 722 F.Supp. at 953; *see Schweiker v. Chilicky*, 487 U.S. 412, 108 S.Ct. 2460, 2468, 2470-71, 101 L.Ed.2d 370 (1988).

Act's jurisdictional bar simply by styling its attack as a claim for collateral damages instead of a challenge to the underlying denial of benefits. If litigants who have been denied benefits could routinely obtain judicial review of these decisions by recharacterizing their claims under state and federal causes of action, the Medicare Act's goal of limited judicial review for a substantial number of claims would be severely undermined. *See Michigan Academy*, 476 U.S. at 680 n. 11, 106 S.Ct. at 2141 n. 11; *Erika*, 456 U.S. at 208-09, 210 n. 13, 102 S.Ct. at 1654-55, 1655 n. 13; *Ringer*, 466 U.S. at 621-22, 627 & n. 14, 104 S.Ct. at 2025, 2028 & n. 14.[6] As a result, Bodimetric's claim is not governed by *Michigan Academy*; instead, it is governed by the terms of *Erika*. It therefore is subject to the exclusive review provisions of section 1395ff.

III.

[5] That Bodimetric's claim is governed by these exhaustive review provisions of the Medicare Act does not end our inquiry, however. Section 405(h) does not facially bar judicial review of every potential action: it precludes only those actions brought "against the United States, the Secretary, or any officer or employee thereof." 42 U.S.C. § 405(h) (1982). Bodimetric argues that Aetna, in its role as fiscal intermediary, does not serve as an "officer or employee" of the United States and is therefore not immune from suit under the Medicare Act.

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[6] In this light, we reject Bodimetric's assertion that "[t]he clearest evidence that [Bodimetric's] claims are not 'inextricably intertwined' is that [Bodimetric] is challenging Aetna's actions as being *outside* the scope of its contract to function as an intermediary." Appellants' Reply Brief at 11. We agree with the *Neiman* district court that "plaintiff cannot escape the reach of *Erika* by characterizing the action against [Aetna] as an '*ultra vires*' claim." 722 F.Supp. at 952.

In addressing this issue, we do not write on a clean slate. In *Trinity Memorial Hospital of Cudahy, Inc. v. Associated Hospital Service, Inc.*, 570 F.2d 660 (7th Cir.1977), we found that the Medicare Act precluded judicial review of Trinity Memorial's claim arising from a cost reimbursement dispute. We therefore reversed the judgment of the district court (which had found jurisdiction) and dismissed Trinity Memorial's claim with respect to all the defendants, *including Associated Hospital Service, Inc.*, the fiscal intermediary administering the Medicare Program. *Id.* at 667-68; *see Marin v. HEW, Health Care Financing Agency*, 769 F.2d 590 (9th Cir. 1985) (affirming dismissal of claim against fiscal intermediary), *cert. denied*, 474 U.S. 1061, 106 S.Ct. 808, 88 L.Ed.2d 783 (1986). And in *Homewood Professional Care Center, Ltd. v. Heckler*, 764 F.2d 1242 (7th Cir.1985), we hinted that certain "unknown federal officials and agents acting in their individual capacities," who were deemed to be covered by section 405(h) when the case was dismissed, included the fiscal intermediary processing Homewood's claims.

We decline to take a different stance here. Congress intended for private organizations (and specifically fiscal intermediaries) to play a "considerable role" in the Medicare reimbursement program. S.Rep. No. 404, 89th Cong., 1st Sess., *reprinted in* 1965 U.S. Code Cong. & Admin. News 1943, 1992-95. Indeed,

> [i]n the performance of their contractual undertakings, the carriers and fiscal intermediaries . . . act on behalf of the Secretary, carrying on for him the governmental administrative responsibilities imposed by the bill. The Secretary, however, would be the real party in interest in the administration of the program, and the Government would be expected to safeguard the interests of his contractual representatives with respect to their actions in the fulfillment of com-

> mitments under the contracts and agreements entered into by them with the Secretary.

Id. at 1995. If dissatisfied claimants could avoid the preclusive effect of section 405(h) by simply bringing suit against the fiscal intermediary instead of the Secretary, the Medicare Act's goals of efficiency and finality would be substantially undermined. Moreover, since Congress apparently did not differentiate between the respective abilities of public and private agencies to serve as fiscal intermediaries, 42 U.S.C. § 1395h(a), we see no reason to allow claimants to proceed against private agencies when they clearly cannot proceed against federal agencies.

In a more general context, such a holding would run contrary to Congress's intent to limit judicial review of Medicare claims in order to relieve the burden on the federal judiciary. In *Erika*, the Supreme Court credited Senator Bennett's remarks in this regard: " 'If judicial review is made available where any claim is denied, as some court decisions have held, the resources of the Federal court system would be unduly taxed and little real value would be derived by the enrollees.' " *Erika*, 456 U.S. at 210 n. 13, 102 S.Ct. at 1655 n. 13. We therefore conclude that suits against fiscal intermediaries are governed by the terms of section 405(h).

IV.

[6] We have determined that Bodimetric's claims against Aetna arise under the Medicare Act and that Bodimetric may not circumvent the terms of section 405(h) simply because a private entity (Aetna) serves a public function. We now must consider whether section 405(h) precludes review of a claim that is brought pursuant to our diversity jurisdiction, 28 U.S.C. section 1332.

Section 405(h) states that "[n]o action against the United States, the Secretary, or any officer or employee thereof

shall be brought *under section 1331 or 1346 of Title 28* to recover on any claim arising under this subchapter." 42 U.S.C. § 405(h) (1982) (emphasis supplied). Curiously, this section, on its face, appears to bar actions brought pursuant to federal question jurisdiction and actions brought against the United States but appears to permit actions brought pursuant to diversity jurisdiction.

Bodimetric's argument here is straightforward: since section 405(h) does not expressly preclude actions brought pursuant to diversity jurisdiction, such actions may be brought against fiscal intermediaries.[7] Unfortunately for Bodimetric, however, a close reading of the statute (and its legislative history) does not support such a straightforward result.

Upon its *original* enactment, section 405(h) barred all actions brought pursuant to 28 U.S.C. section 41, which, in turn, "contained [virtually] all of the grants of jurisdiction to the United States district courts under Title 28," including the predecessor to the current diversity grant, 28 U.S.C. section 1332, *Northlake Community Hosp. v. United States*, 654 F.2d 1234, 1239 n. 5 (7th Cir.1981); *see* Social Security Act Amendments of 1939, Pub.L. No. 379, § 205(h), 53 Stat. 1360, 1371 (1939); *Salfi*, 422 U.S. at 756 n. 3, 95 S.Ct. at 2462 n. 3. At that time, therefore, there was little question that section 405(h) barred claims based upon diversity jurisdiction.

In 1976, however, the Office of Law Revision Counsel "revised" section 405(h) from its general bar of jurisdiction to its present form, which seems to preclude only those ac-

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[7] Although Bodimetric's complaint included a civil RICO count, it has withdrawn this count on appeal for purposes of federal jurisdiction. Appellants' Brief at 46 n. 18. We therefore concentrate solely on Bodimetric's state law claims brought pursuant to diversity jurisdiction.

tions "brought under section 1331 or 1346 of Title 28," and not those actions brought under the other jurisdictional sections, including 28 U.S.C. section 1332:

> In subsec. (h), "section 1331 or 1346 of Title 28" was substituted for "section 24 of the Judicial Code of the United States" on authority of Act June 25, 1948, c. 646, 62 Stat. 869, section 1 of which enacted Title 28, Judiciary and Judicial Procedure. Prior to the enactment of Title 28, section 24 of the Judicial Code was classified to section 41 of Title 28. Jurisdictional provisions previously covered by section 41 of Title 28 are covered by sections 1331 to 1348, 1350 to 1357, 1359, 1397, 1399, 2361, 2401, and 2402 of Title 28.

42 U.S.C.A. § 405 (West 1982) (codification note). Since Congress had not yet approved this apparent revision, original section 405(h)—with its bar on claims brought pursuant to federal courts' diversity jurisdiction—still controlled to the extent that original section 405(h) conflicted with the newly codified version.[8] See Act of June 30, 1926, Pub.L. No. 440, Ch. 712, codified at 1 U.S.C. p. LXXV (1988) ("In case of any inconsistency arising through omission or otherwise between the provisions of any section of the Code and its corresponding portion of legislation heretofore enacted effect shall be given for all purposes whatsoever to such enactments."); *Stephen v. United States*, 319 U.S. 423, 426, 63 S.Ct. 1135, 1136, 87 L.Ed.

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[8] We therefore must disagree with the apparent conclusion reached implicitly (before Congress enacted revised section 405(h)) by the Eighth Circuit in *Rochester Methodist Hospital v. Travelers Insurance Co.*, 728 F.2d 1006 (8th Cir. 1984), and by the District of Puerto Rico in *Hospital San Jorge, Inc. v. Blue Cross Association*, 1977 (Transf. Binder) Medicare & Medicaid Guide (CCH) ¶ 28,306 (D.P.R.1976), that seems to permit claimants to maintain actions against fiscal intermediaries based upon diversity jurisdiction. Neither court, however, squarely addressed the revision of section 405(h) or the legislative history accompanying it.

1490 (1943) ("[T]he Code cannot prevail over the Statutes at Large when the two are inconsistent.").

But Congress eventually did act upon this revision. In enacting the Deficit Reduction Act of 1984 ("DEFRA"), Congress adopted the codifier's revised language by placing in Subtitle D (labelled "Technical Corrections" and containing numerous such changes) the following language: "Section 205(h) of such Act is amended by striking out 'section 24 of the Judicial Code of the United States' and inserting in lieu thereof 'section 1331 or 1346 of title 28, United States Code,'." Pub.L. No. 98-369, 98 Stat. 1162, § 2663(a)(4)(D). *At the same time,* Congress cautioned the courts not to interpret DEFRA's "Technical Corrections" as substantive changes:

> [T]he amendments made by section 2663 shall be effective on the date of the enactment of this Act; *but none of such amendments shall be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date.*

Id., § 2664(b) (emphasis supplied). In this section, Congress clearly expressed its intent not to alter the substantive scope of section 405(h). Because the previous version of section 405(h) precluded judicial review of diversity actions, so too must newly revised section 405(h) bar these actions. Any other interpretation of this section would contravene section 2664(b) by "changing or affecting [a] right, liability, status, or interpretation" of section 405(h) that existed before the Technical Corrections were enacted.[9] *See Griffin v. Oceanic Contractors, Inc.*, 458

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[9] Neither party has explained *why* Congress enacted revised section 405(h), nor has our independent review of the legislative history shed any light on the inquiry. Indeed, Bodimetric has not explained why Congress would want to preclude judicial review of federal question

U.S. 564, 571, 102 S.Ct. 3245, 3250, 73 L.Ed.2d 973 (1982) (when "in rare cases the literal application of a statute will produce a result demonstrably at odds with the intentions of its drafters . . . those intentions must be controlling."); *Muniz v. Hoffman*, 422 U.S. 454, 470, 95 S.Ct. 2178, 2187, 45 L.Ed.2d 319 (1975) ("It will not be inferred that the legislature, in revising and consolidating the laws, intended to change their policy, unless such an intention be clearly expressed.") (quoting *United States v. Ryder*, 110 U.S. 729, 740, 4 S.Ct. 196, 201, 28 L.Ed. 308 (1884)); *cf. United States v. Thompson*, 319 F.2d 665, 669-70 (2d Cir. 1963); *Prudencio v. Hanselmann*, 178 F.Supp. 887, 888-89 (D.Minn.1959). Bodimetric's challenge to Aetna's method of processing its claims, therefore, is directly controlled by the provisions of section 405(h). The district court thus properly found that it lacked subject matter jurisdiction to consider Bodimetric's claims.[10]

V.

By enacting the exclusive review provisions of the Medicare Act, Congress expressly limited the remedies that can be sought by dissatisfied claimants from fiscal in-

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claims but permit judicial review of state law claims under diversity jurisdiction. In any event, given the clear cautionary language of DEFRA section 2664(b), we find that Congress, in enacting revised section 405(h), did not intend to treat diversity claims differently than federal question claims. Both are subject to the limited review provisions of section 405(h).

[10] Since we have concluded that the district court did not have subject matter jurisdiction to entertain Bodimetric's claims, we need not address Aetna's defense of official immunity, nor do we have occasion to consider the government's motion to intervene.

termediaries. While this may, in some cases, foreclose avenues of relief generally available to civil litigants, it is also the system Congress clearly intended to implement. Any decision to modify this aspect of the system must be made by Congress, not by the courts.

AFFIRMED.

UNITED STATES DISTRICT COURT
N.D. ILLINOIS, E.D.

No. 87 C 3465

BODIMETRIC HEALTH SERVICES, INC., ET AL., PLAINTIFFS,

v.

AETNA LIFE & CASUALTY, ET AL., DEFENDANTS,

UNITED STATES OF AMERICA, INTERVENOR.

Feb. 9, 1989

MEMORANDUM AND ORDER

MORAN, District Judge

Plaintiff American Service Bureau ("ASB"), and two of its subsidiaries, Bodimetric Health Services, Inc. ("BHS") and Bodimetric Home Health Care, Inc. ("BHC"), bring this action against defendants Aetna Life & Casualty and Aetna Life Insurance Company (collectively referred to as "Aetna"), alleging fraud and wrongful misconduct in the processing of their claims to reimbursement under Title XVIII of the Social Security Act, 42 U.S.C. § 1395 *et seq.* ("Medicare Act" or "Act"). Plaintiffs, Illinois corporations, previously provided home health care and related services to Medicare patients across the nation.

In 1984 plaintiff BHS nominated Aetna to act as its fiscal intermediary pursuant to 42 U.S.C. § 1395h. Plaintiffs allege that Aetna, in its zeal to impress the government with its effectiveness in reducing health-care costs, arbitrarily and unlawfully denied plaintiffs reimbursement to which they were entitled, engaging in a pattern of

fraudulent practices designed to ruin plaintiffs' business. Plaintiffs recite claims under various state tort theories and the federal Racketeer Influenced and Corrupt Organizations Act, 18 U.S.C. § 1964(c) ("RICO"). The United States seeks intervention and, together with Aetna, moves to dismiss, raising jurisdictional and immunity defenses. We deny the motion for intervention as moot and grant the motion to dismiss.

BACKGROUND

The Medicare program provides health insurance for the aged and disabled under the Social Security Amendments of 1964, Pub. L. No. 89-97, Title 1, 79 Stat. 286 (1965). The Department of Health and Human Services ("HHS") administers the program through the Health Care Financing Administration ("HCFA"). Reimbursement under the program is divided into two parts: Part A of the Medicare program covers the costs incurred by eligible beneficiaries for certain hospital and home health services (§§ 1395c-1395i-2); Part B provides elective supplemental coverage for certain expenses, including physicians' fees and laboratory tests (§§ 1395j-1395w).

HHS reimburses home health care providers the cost of services, including part-time or intermittent care provided by nurses and/or home health aides; physical, occupation or speech therapy; and medical social services rendered under the direction of a physician. Section 1395y(a)(1)(A) precludes reimbursement for services "which . . . are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." To that end, in order to be reimbursed for home health services, § 1395f(a)(2)(C) requires certification by a physician that the services were needed, that the individual was confined to the home (with some exceptions), and that there was a developed plan—with periodic review—for the administration of

such services under the supervision of a physician ("plan of treatment"). Home health care providers are entitled to reimbursement of the lesser of their customary charges or reasonable costs, including operational costs of related organizations (§ 1395f(b)).

Under the terms of the Act private organizations play a "considerable role" in the administration of both the hospital insurance and supplementary plans. *See* S.Rep. No. 404, 89th Cong., 1st Sess., *reprinted in* 1965 U.S. Code Cong. & Admin. News 1943, 1992. Section 1395h permits health care providers to nominate a public or private agency to act as a fiscal intermediary for the purposes of facilitating payments under Part A of the program.[1] The Secretary of HHS is authorized to contract with such an agency to provide "for the determination . . . of the amount of the payments required . . . to be made to [eligible health care] providers" (§ 1395h(a)). Those contracts require the fiscal intermediary to review claims for compliance with coverage requirements, determine the reasonable cost of services, make payments directly to health care providers, provide consultative services, communicate to providers any information or instruction from HCFA, audit provider records and assist with utilization review activities. *Id.*, 42 C.F.R. § 421.100; Intermediary Agreement, Amended Complaint, Exhibit 1, Article II. The intermediary reviews, processes and pays claims of a provider throughout the year on a per-visit basis. At the end of the fiscal year the provider submits a cost report which is audited by the fiscal intermediary, who then issues a determination as to the final amount of reimbursement due to the provider by Medicare, and it reconciles claim payments made during the year to determine any overpayment or underpayment (42 U.S.C. § 1395g).

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[1] Private organizations providing reimbursement under Part B are called carriers. *See* 45 Fed.Reg. 42174 (June 23, 1980).

If a claim for reimbursement under the Act is denied, health care providers may request a reconsideration by the intermediary, 42 C.F.R. §§ 405.710(b), 405.711. If the claim exceeds $100, the provider has the right to be heard before an administrative law judge ("ALJ"), 42 C.F.R. § 405.720, and may also request review by the Appeals Council, 42 C.F.R. § 405.724. If the amount in controversy exceeds $1,000, the provider may appeal to the United States District Courts, 42 C.F.R. § 405.730. Congress intended the remedies provided by these review procedures to be exclusive. *See* S.Rep. No. 404, *supra* at 1995.

Congress drafted the provisions of the Act with the intention that private health care organizations would employ their administrative expertise to aid HCFA in managing the program. *See* S.Rep. No. 404, *supra* at 1976 (describing a role for private agencies in framing regulations under the Act's provisions), 1990 (noting that state agencies and private organizations would have a "major administrative role"). In anticipation of the complications which might arise from the involvement of private entities in the administration of such a large public program, Congress provided the Secretary with authority to indemnify intermediaries against certain liabilities:

> In the performance of their contractual undertakings, the carriers and fiscal intermediaries would act on behalf of the Secretary, carrying on for him the governmental administrative responsibilities imposed by the bill. The Secretary, however, would be the real party in interest in the administration of the program, and the Government would be expected to safeguard the interests of his contractual representatives with respect to their actions in the fulfillment of commitments under the contracts and agreements entered into by them with the Secretary.

Id. The original HHS regulations borrowed language directly from the Senate Committee's report. *See* 20

C.F.R. § 405.670 (1970); *Kuenstler v. Occidental Life Insurance Co.*, 292 F.Supp. 532, 535 (C.D. Calif. 1968). In 1980, HHS reorganized and renumbered these regulations. 45 Fed.Reg. 42178 (June 23, 1980). The text of the revised version was slightly altered:

> *Indemnification of intermediaries and carriers.* Intermediaries and carriers act on behalf of HCFA in carrying out certain administrative responsibilities that the law imposes. Accordingly, their agreements and contracts contain clauses providing for indemnification with respect to actions taken on behalf of HCFA and HCFA is the real party of interest in any litigation involving the administration of the program.

42 C.F.R. § 421.5(b).

Guided by these principles, Aetna and HHS entered into an agreement which provides:

> In the event the Intermediary or any of its directors, officers, employees, or other persons who are engaged or retained by the Intermediary to participate directly in the claims administration process, are made parties to any judicial or administrative proceeding arising, in whole or in part, out of any functions of the Intermediary under this agreement in connection with any claims for benefits by any . . . provider of services, the Secretary shall, to the extent permitted by law, hold the Intermediary harmless for all judgments, settlements . . . awards, and costs, in favor of such . . . provider of services, incurred by the Intermediary or any of its directors, officers, or employees or other persons who are engaged or retained by the Intermediary to participate directly in the claims administration process, in connection therewith.

However, the agreement further provides that the Aetna shall reimburse HHS for

> any valid judgment or award paid by the United States in the discharge of the Secretary's obligations

> under this Article if the liability underlying the judgment or award was the direct consequence of conduct on the part of the Intermediary determined by judicial proceedings or the agency making the award to be criminal in nature, fraudulent, or grossly negligent; provided, however, the Intermediary shall not be required to reimburse the Secretary that portion of an award or judgment directly attributable to an allowable program benefit under Title XVIII of the Act.

Plaintiffs' allegations

Plaintiff BHS was the owner of a chain of home health agencies qualified to provide services under the Medicare program. BHS agencies began servicing Medicare patients in 1980 and were then reimbursed by the Office of Direct Reimbursement ("ODR"), a component of HCFA. Plaintiffs allege they were rarely denied reimbursement for their claims by ODR (am. cplt. ¶ 20). In 1984, BHS nominated Aetna as its intermediary and continued to receive reimbursement for virtually all of the claims that it submitted. Those claims included costs incurred by ASB as a related organization under the Secretary's regulations, 42 C.F.R. § 413.17.

Plaintiffs allege that "in or about January, 1985, HHS performed a contractor evaluation . . . which was critical of Aetna's performance as a fiscal intermediary. At that time, an inordinate number of claims purposely had not been reviewed by Aetna" (am. cplt. ¶ 23). Subsequent to this critical review, "Aetna, secretly, arbitrarily and without informing [plaintiffs] began policy changes in its review process and formulated rules for review that were withheld from BHS" (am. cplt. ¶ 24).

Plaintiffs assert a number of ways in which Aetna acted beyond the scope of its contractual authority and fraudulently denied claims for its own ends. First, Aetna alleg-

edly required claims to contain certain "buzzwords," without which the claims were considered improper, although Aetna never informed BHS of this requirement. Employing this technique, Aetna denied thousands of claims—as many as 75 per day—without regard to their underlying substance. Second, the amended complaint contains allegations that Aetna arbitrarily denied claims as medically unnecessary, knowing that BHS would nevertheless receive some of those funds via the "waiver of liability" provisions of 42 U.S.C. § 1395pp and 42 C.F.R. § 405.330 and therefore would probably not appeal those denials. Then Aetna employed a method plaintiffs call "linked denials." Under the Medicare Act unskilled home health care, such as services from a home health aide, is covered only where the individual received skilled home health care as well. Plaintiffs allege that Aetna denied all claims based upon the services of home health aides in those instances where Aetna wrongfully and unlawfully determined the skilled services to be medically unnecessary. Third, Aetna allegedly denied claims for the reason that accompanying documentation was not submitted, in some instances claiming that plaintiffs neglected to pay sufficient postage. Plaintiffs, however, allege that BHS officials personally supervised the mailing of the supporting documents, some of them three to six times. Finally, plaintiffs complain that they submitted claims that were in compliance with the requirement that services be rendered in accordance with a plan of treatment but Aetna denied them anyway. They allege that Aetna employed the concept of "treatment week" (counting from the day of the beneficiary's first visit) rather than "calendar week" in determining compliance with the plan of treatment, although ODR, plaintiffs claim, had always employed the calendar week. However, since Aetna secretly used the treatment week, it determined that numerous claims were not rendered in accord-

ance with physicians' orders and denied claims arising therefrom. Plaintiffs allege that Aetna agreed to reimburse plaintiffs for denials under this rubric occurring prior to May 1, 1985, although they have not yet fulfilled this promise.

Plaintiffs describe a pattern or practice which was designed to lull them into believing that the onslaught of denials was the fault of plaintiffs, so BHS would not terminate its relationship with Aetna. After a flurry of denials in January 1985, BHS requested a meeting with Aetna, which was held on February 27. Plaintiffs allege that Aetna falsely represented that the denials were extraordinary events caused by efforts to catch up on a backlog of claims. Aetna did not inform BHS that it needed to change either its form of documentation or its provision of home health services. After further denials BHS again met with Aetna in May, when the intermediary falsely represented that the denials were due to reductions in Aetna's staff from federal funding cutbacks, but that at that time Aetna was caught up in its review. Plaintiffs also recount a series of letters and telephone calls where Aetna officials represented that they were following regular procedure and were not to blame for the denials.

As evidence showing Aetna's bad faith in the processing of their claims, plaintiffs allege that they have received an 88% reversal rate for the "medically unnecessary" denials which they appealed. In cases where BHS has entered an appearance and argued for reversal, the ALJs have reversed approximately 99% of the denials. Plaintiffs further claim that Aetna did not consider these reversals when calculating the amount of protection BHS could receive under the waiver of liability provisions, causing even further damage. Plaintiffs also claim that Aetna was directed to deny $5 in claims for every dollar allowed,[2] but carried

[2] It is not clear who directed Aetna to create a five-to-one denial ratio. In their amended complaint plaintiffs accuse Aetna's Connecti-

forth this mission with such vigor that they achieved a 22.1-to-one ratio, far higher than any other Medicare fiscal intermediary.

Plaintiffs allege that, due to Aetna's misconduct, they have been forced to close their home health agencies and have suffered damages in excess of $8,000,000. Plaintiffs claim that Aetna has engaged in this fraudulent and deceiving practice against a number of providers, and the amended complaint contains specific allegations of the financial ruin of various other home health care agencies, including St. Vincent's Memorial Hospital Home Health Care, Harrisburg Medical Center Home Health Agency, Alexian Brothers Home Health Care, and Beverly Home Health Care.

DISCUSSION

Aetna moves to dismiss the amended complaint, arguing that plaintiffs' claims are precluded by the statutory scheme of the Medicare Act, that Aetna is entitled to both official and sovereign immunity, that such immunity is absolute, and that plaintiffs' state law tort and federal RICO claims are preempted by the Medicare Act. Plaintiffs recognize, correctly, we believe, that those various doctrines are intertwined because all of them rest, ultimately, on a determination of the extent to which a provider can seek relief against a fiscal intermediary for the perceived wrongs of that agency, when that agency is performing an administrative function for the government. That determination is complicated here both because the legal concepts are complex, do not lend themselves to bright line standards, and often lead to somewhat conflicting judicial deci-

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cut supervisors of this policy, although they also allege, in their memorandum opposing the government's intervention, that this policy came from HHS.

sions and because a fiscal intermediary is a somewhat unique legal animal.

We have stated plaintiffs' allegations at some length because a characterization of those allegations is central to plaintiffs' ability to proceed here. Oversimplified, plaintiffs' contentions are that their suit is against private parties for RICO violations and common law tortious conduct beyond the scope of their authority and contrary to their contractual obligations to the government. Plaintiffs contend that they are attacking the defendants' methodology. Those violations and torts do not arise under the Medicare Act and have caused plaintiffs injury, independent of whatever reimbursement claims they may have for services provided. Defendants contend that the suit is, essentially, an action against an instrument of government, bottomed on claims that the providers were not properly paid for the services they provided – claims which can only be reviewed through and to the extent provided by a statutory administrative process.

Can plaintiffs' allegations be teased into the legal model they present to escape dismissal? We think not.

[1] First, we deal with certain matters which because of the views expressed here are not outcome-determinative. The Secretary seeks to intervene either as a matter of right or by permissive intervention. That petition fully sets forth the Secretary's position, the complaint seeks no relief against the government, and we are dismissing the complaint. In those circumstances we see no purpose to be served by considering that petition and we deny it as moot. Both plaintiffs and defendants try to use the indemnity provisions to bolster their positions, defendants by suggesting that the government and public monies are therefore more directly involved and plaintiffs by arguing that the indemnities indicate that the Secretary thought that fiscal intermediaries could be liable to providers and that

therefore that must be so. Government cannot, however, extend a protective cloak by choosing to indemnify, *Group Health Inc. v. Blue Cross Ass'n*, 625 F.Supp. 69, 76 (S.D.N.Y. 1985), *appeal dismissed*, 793 F.2d 491 (2d Cir. 1986) (jurisdiction lacking), *cert. denied*, 480 U.S. 930, 107 S.Ct. 1566, 94 L.Ed.2d 758 (1987); *Kolpak v. Bell*, 619 F.Supp. 359, 372 (N.D.Ill. 1985), and an indemnification obligation is far too weak a reed upon which to rest the creation of substantive obligations and remedies. No one disputes that defendants could be liable at least for constitutional torts. And in a complex and uncertain legal area simple prudence dictates that the ultimate burden of judgments be assigned in the event that some court should determine that there could be such judgments.

[2] Further, we question whether sovereign immunity is directly implicated here. The government is not a defendant. Plaintiffs do not seek recovery from the public fisc nor request an injunction to compel or restrain Aetna in its official capacity. Sovereign immunity does not come into play since in "a suit against the officer to recover damages for the agent's personal actions . . . the judgment sought will not require action by the sovereign or disturb the sovereign's property." *Larson v. Domestic & Foreign Commerce Corp.*, 337 U.S. 682, 687-88, 69 S.Ct. 1457, 1460-61, 93 L.Ed. 1628 (1949). Finally, the concepts of official immunity may be implicated, but we do not rest upon that concept. The policy considerations inherent in that concept, however, and inherent in sovereign immunity doctrine for that matter, also, are germane to the determining issue in this case, and that is preemption in various guises.

[3] In broad terms, official immunity protects those who, as the government representatives, carry out the government's directives. The Federal Torts Claims Act adopts that model, although it does so through a limited waiver of

sovereign immunity: a party suffering an injury at the hands of a government employee can sue the government within the parameters of the statute but cannot sue the employee. The official immunity doctrine arises from judicial decision rather than by statute but speaks to the same end, protecting the government's representative from having to justify his discretionary decisions in court so as not to inhibit the exercise of his judgment. That means, of course, that the wicked can go unpunished and the injured may be left without a remedy. If the representative is acting within the outer reaches of his scope of authority he is immune, even if the motives and purposes of his actions are improper and ignoble. In the absence of judicially-related immunity, however, he is still answerable for constitutional torts, but such are not alleged here.

[4] The burden of defendants' contentions is that plaintiffs are, essentially, challenging benefits determinations; that the sole means of mounting that challenge is through the administrative mechanism, that 42 U.S.C. § 1395ff and 42 U.S.C. § 405(h), as well as the general doctrine of exhaustion of administrative remedies, expressly establish this administrative procedure as the exclusive mechanism for review of all benefit claims and of all actions "inextricably intertwined" with such claims, *Heckler v. Ringer*, 466 U.S. 602, 614-617, 104 S.Ct. 2013, 2021-23, 80 L.Ed.2d 622 (1984). They further contend that while the present form of § 405(h) does not expressly refer to diversity actions or to RICO, the present form is a recodification of a prior enactment which did negate diversity actions, the recodification was enacted with the express representation that it resulted in no substantive changes, RICO was enacted subsequent to present § 405(h), and recognizing that later specific jurisdictional grant as a basis for this action would conflict with the congressionally-crafted administrative scheme. In short,

defendants urge that Congress adopted a system for challenging benefit determinations and providers cannot, by creative lawyering, avoid the strictures of that system. We agree.

Plaintiffs concede that the administrative benefits determination procedure is exclusive, but they contend that they do not challenge determinations or seek to recover claims here. They characterize their complaint as one against defendants for their own private wrongdoing: the failure to provide advice, to inform them of procedures and interpretations and to safeguard and act upon submissions; the improper use of hypertechnical formulations of the claims ("buzzwords"); the arbitrary changes in the time standard; and the fraudulent motives that pervaded the whole process. They insist that they can prove a pattern or practice without proving their entitlement to specific determinations through computer models, sampling or the like. They point out that they cannot appeal administratively many claims, particularly unskilled claims, when the linked skilled claims have been paid under the Secretary's waiver system.

Although plaintiffs thus characterize their complaint, we conclude that their claims are, at bottom, for a review of the intermediary's benefits determinations. First, plaintiffs' damages flow directly from benefit denials and defendants are entitled to dispute plaintiffs' conclusions claim-by-claim. Congress intended to preclude federal review of such individual determinations. Second, the underlying allegations concerning Aetna's actions provide a basis for plaintiffs' administrative challenges under § 1395ff. True, the Secretary cannot adjudicate plaintiffs' claims under RICO and the common law; yet RICO and the common law would simply provide plaintiffs with theories to recover the value of lost benefits and consequential damages in a case where the underlying facts

could be raised in the administrative process. This case is therefore unlike *Bowen v. Michigan Academy of Family Physicians*, 476 U.S. 667, 678, 106 S.Ct. 2133, 2140, 90 L.Ed.2d 623 (1986), where the plaintiffs were foreclosed from challenging the Secretary's regulations administratively.

Third, and most important, to prove their claims plaintiffs must rely in a dispositive manner on the standards of the Medicare Act and Aetna's contract with the Secretary. The underlying claim of fraud would necessitate a showing that defendants violated a duty owed to them, and the contours of that duty are found in the Act and the regulations. Plaintiffs must also rely on the denial of an entitlement under the Act to establish the injury required by standing doctrine. Since "both the standing and the substantive basis for the presentation" of plaintiffs' claims are, in considerable part, the Medicare Act, § 405(h) precludes jurisdiction. *See Weinberger v. Salfi*, 422 U.S. 749, 760-61, 95 S.Ct. 2457, 2464-65, 45 L.Ed.2d 522 (1975).

Plaintiffs argue that they are attacking "methodology" rather than benefit determinations. This very claim was rejected by the Supreme Court in *Ringer*, 466 U.S. at 614, 104 S.Ct. at 2021, where the plaintiffs claimed that the Secretary employed an unlawful presumption that certain surgical operations could not be reimbursed under the Act. In the cases that followed *Michigan Academy*, courts have made clear that while jurisdiction is proper to adjudicate challenges to the Secretary's regulations, it is lacking when the claim is merely that the intermediary or carrier misapplied or misinterpreted valid rules or regulations. *See, e.g., Kuritzky v. Blue Shield of Western New York*, 850 F.2d 126 (2d Cir. 1988), *cert. denied*, ___ U.S. ___, 109 S.Ct. 787, 102 L.Ed.2d 778 (1989); *McCuin v. Secretary of HHS*, 817 F.2d 161, 164-66 (1st Cir. 1987); *Linoz v. Heckler*, 800 F.2d 871, 876 (9th Cir. 1986); *Neiman v.*

Secretary of HHS, Medicare & Medicaid Guide (CCH) ¶ 37,569 (E.D.N.Y. Sept. 21, 1988) [1988 WL 127456]; *Griffith v. Bowen*, 678 F.Supp. 942 (D.Mass. 1988). As stated in *Kuritzky*, "method" does not mean carrier practice, but the method set forth in the Secretary's regulatory scheme. 850 F.2d at 128.

Aetna acted in its capacity as fiscal intermediary when it reviewed plaintiffs' claims, even if it reviewed them improperly for base and fraudulent reasons. Plaintiffs' charges here are therefore inextricably intertwined with benefit determination and must first be processed through the system Congress and the Secretary chose. Although that system may not provide review for all determinations, and may not provide plaintiffs' compensation for consequential damages, this court cannot now make its own determination that thousands of services were reasonable and necessary and that therefore thousands of benefits should have been paid.

CONCLUSION

We conclude that plaintiffs' claims are inextricably intertwined with Medicare benefit determinations—claims which Congress intended to confine to the administrative process. We therefore grant defendants' motion, and this cause is dismissed. The government's motion to intervene is denied as moot.